FORM 1144

STATE OF HAWAII
Department of Human Services
Med-QUEST Division

Page number: _____ of _____
☐ US – Urgent Req. for Svcs.

Hawaii–Medicaid
P.O. Box 2561
Honolulu, Hawaii 96804-2561

REQUEST FOR MEDICAL AUTHORIZATION

Check only 1 – Different Types of Service Must Be Requested on Separate 1144 Forms.

☐ ED – EPSDT/MF CM Svcs.
☐ OP – Outpatient Facility (UB-92)
☐ DE – Dental
☐ DM – Appl./DME/Sup.
☐ OS – Out of State Svcs.
☐ BH – Psych. Testing/ & Detox
☐ GT – Transportation
☐ LN – Sign Language Interp.
☐ IC – Incontinence Supplies
☐ LT – Long Term Care
☐ HE – Home Health
☐ MD – Professional Svcs. (CMS 1500)
☐ RE – Rehab. Svcs.
☐ Drugs – INCORRECT FORM

NOTE: INCOMPLETE FORM WILL DELAY THE AUTHORIZATION PROCESS: Approval of this request is not an authorization for payment or an approval of charges. Payment by the Medicaid Program is contingent on the patient being eligible and the provider of service being certified by Medicaid. The provider of service must verify patient eligibility at the time the service is rendered. **Authorization expires 60 days from date of approval** unless otherwise noted by the consultant. **Will not approve PA if more than one supplier on form.**

Medicaid ID Number	Patient's Name (Last, First, M.I.)	Date of Birth ☐ M ☐ F
Medicare Coverage? ☐ Yes ☐ No Is patient receiving Medicare Home Health Benefits? ☐ Yes ☐ No	Currently at: ☐ Home ☐ Hospital ☐ SNF/ICF/ICF-MR Facility ☐ Other: _____ Patient's Mailing Address (St., City, Zip)	Expanded Early & Periodic Screen. Diagnosis & Trtmnt (EPSDT): ☐ Yes ☐ No

PHYSICIAN SECTION

Diagnosis(es): _____

Justification: (Attachment ☐) _____

PHYSICIAN SECTION				**SUPPLIER SECTION**			
Procedure Code	Service/Description	QTY	Period Requested From: To:	Purchase Price	Rental Price	Repair Price	Serial #
1.							
2.							
3.							
4.							

Physician Section for Incontinence Supplies

Additional justification from physician is needed for quantities exceeding 200 diapers, 50 underpads and 50 pairs of gloves.

1. Recipient requires diapers	2. Recipient requires underpads	3. Caregiver requires gloves	4. Additional justification attached
☐ Yes ☐ No # of diapers used per mo.: _____	☐ Yes ☐ No # of underpads used per mo.: _____	☐ Yes ☐ No # of pairs used per mo.: _____	☐ Yes ☐ No

Supplier Section for Incontinence Supplies

Code	**Item**	**QTY/Mo.**	**Period Requested**	
W4335	Diapers/Adult Small/All Children's		From:	To:
A4335	Diapers/Adult Medium/Large			
W4336	Diapers/Adult/Extra Large			
A4554	Underpads, Large			
A4927	Gloves, Latex (pairs)			
W4928	Gloves, Non-Latex (pairs)			

I attest that the above-named recipient is under my care and that the requested services are medically necessary.

Physician's signature		Provider #	Contact name
Physician's name (print)	Date	Telephone	Fax #

Supplier's signature		Provider #	Contact name
Supplier's name (print)	Date	Telephone	Fax #